VILLAGE HOSPITAL IN EAST PAKISTAN

medical missionary

MAY-JUNE, 1962

Mary is the earth in which the Church was sown. In her womb the whole Church was betrothed to the Word. The Father's plans for the nuptials of His royal Son concern at once, Mary, the Church and each of its members. For the Son of God passed from the heart of the Father into the womb of Mary and from Mary's womb into the bosom of the Church. Mary is the sun in which God first sets His dwelling, and She is the bridal chamber in which the Church is linked to Christ as bride. As a Bridegroom He comes forth from her inviolate womb, rejoicing to unite Holy Church to Himself. And the bride is in every respect like the bride in whose womb she was given birth. For like Christ's mother, the Church is wed but virgin, and she too conceives virginally by the Holy Spirit and bears virginally without travail.

She is mother because she brings forth daily Him whom the Virgin Mary brought forth, presenting God with new sons in Baptism. Her role is like that of Mary, total consecration to Christ, complete openness to the divine, sensitiveness to the action of God's Spirit, readiness with the answer of faith. She also is the Lord's handmaiden, and she is never at the end of her labors to deliver us to the life of the Spirit. The Mother of God's Magnificat is in her mouth for all the centuries. In the midst of sorrow she stands and believes in the joy of redemption. Finally, the glorious destiny of the whole body of the Church and each of its members is fully realized in Mary's bodily Assumption and exaltation to immortality.

compiled from patristic sources.

MATER ECCLESIAE

Mary in the Fathers of the Church
third in a series
MARY, MOTHER AND TYPE OF THE CHURCH

VOL. 36, NO. 3

THE medical missionary

May-June 1962

Published by

THE MEDICAL MISSION SISTERS—PHILADELPHIA 11, PA.

THE MYMENSINGH STORY

VILLAGE HOSPITAL IN EAST PAKISTAN
Sister M. Christine

BENGALI LANGUAGE
Rachel Van Meter

CUSTOMS AND COSTUMES
Sister M. Thomas

PAKISTAN'S GOLDEN FIBER: JUTE
Sister M. Lourdes

TIRONI
Sister M. Claude

BOOKS
Sister M. Fabian

EXPECTING THE UNEXPECTED
Sister M. Terence

Cover Photo

Mother M. Benedict with children, in Mymensingh.

Photo Credits

Cover: John Primi; 66 (r): Black Star; 66 (top), 82, 83, 85: Pakistan Information; 69: WHO; 92: UNICEF; 96: Der Feuerreiter.

The Medical Missionary is Published Bi-Monthly with Ecclesiastical Approbation by the Society of Catholic Medical Missionaries, Inc. Subscription: 1 yr. $2.00; 2 yrs. $3.00. 2nd Class Postage paid at Phila., Pa.

EDITOR: Sr. M. Angelica; Business: Sr. M. Kevin; Art: Sr. M. Lawrence, Frank X. Smith

Mymensingh. Pakistani father brings his baby boy, suffering from fever, to Mother Mary Benedict, M.D.

The mymensingh story

IN August, 1947, the Indian sub-continent was divided into two sovereign states, the Dominions of India and Pakistan. It was just one year after this event, in September, 1948, that two Medical Mission Sisters came to Mymensingh, located on the Bramaputra River in East Pakistan, one of the hottest, wettest places in the world.

In the Spring of 1947 the Sisters had visited the proposed hospital site—adjoining the Holy Cross Fathers' Mission in Mymensingh. The new hospital was to serve a population of six million people—for the most part poor villagers, living in bamboo huts—eating only one meal a day. The site was located at the edge of the town and consisted of a small building and some rice fields, which were under water for most of the year. The approach to the house from the mud path, which boasted the name of a road, was past a *pushkarini* (pond)—the brilliant red water lilies and reflected blue sky make a delight-

ful picture. Electrical cables had been laid two years previously in anticipation of the Sisters' coming. An upper story was now added to the house and wiring completed. Meantime, the Sisters stayed with the Catechist Sisters of Mary Immaculate just across the "road," and on September 13th moved into their own new quarters.

By the 15th, the chapel was ready and Father Voorde, C.S.C., the Pastor, offered the first Mass. The blessing of the house took place on September 29th, Feast of St. Michael, Patron of the chapel and hospital-to-be. A young woman from the village came daily to help with the housekeeping, so that she would be in the routine by the time the hospital was opened. She coped with the mud stove in the mornings, and helped with the marking of the precious linens in the afternoons. Rationing, due to "partition," was still severe and food and cloth almost unobtainable—even the sheets needed for the hospital beds!

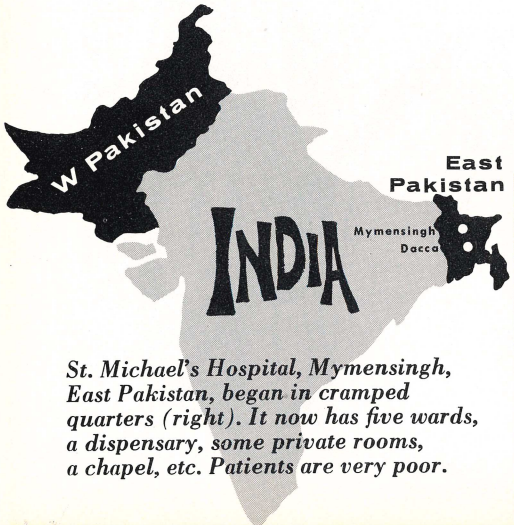
The missionaries of the diocese, the Holy Cross Sisters, the Sisters of Notre Dame of the Missions, the Cathechist Sisters of Mary Immaculate and the Holy Cross Priests all gave in their poverty: pieces of furniture, sample medicines, blankets and, best of all, their interest and neighborliness in helping put things in order. Father Wyss, C.S.C., donated generously of his time and labor, planning and working on the new hospital building. Excessive rains caused many setbacks. The posts had to be cut; the windows and door frames made; the bricks, rubble, sand, and cement procured.

Finally, Sister M. Benedict, the doctor and surgeon, arrived in October from the U. S., laden with many crates filled with all kinds of hospital supplies and equipment, army surplus for the most part.

Then—early in November, the first post (cornerstone) was put in. Uprights were cemented in the ground—no basements here, the ground is too damp—and the cement floor was laid. The asbestos roof was put on — the building began to take shape. It was a long, low, shed-type of building, with plasterboard partitions and woven bamboo ceilings. The shallow well supplied water for ordinary needs until the tube well was sunk. To a song in rhythm of their own concocting, seven men spent about seven days "seesawing" this tube into the ground. During the last 48 hours the process is continuous, so that one needs cotton in one's ears to get a little sleep.

In February, patients began to come before the Sisters had beds to put them in . . . and the 45-bed hospital was formally announced "open" on March 19, 1949, Feast of St. Joseph.

It took time, firmness, patience, and understanding of the peoples' background, and problems, for the Sisters to win their confidence . . . but they did.



St. Michael's Hospital, Mymensingh, East Pakistan, began in cramped quarters (right). It now has five wards, a dispensary, some private rooms, a chapel, etc. Patients are very poor.

VILLAGE HOSPITAL IN EAST PAKISTAN

SISTER M. CHRISTINE, M.D.

FOREIGN visitors are whisked through selected streets of the "big" cities of Dacca (558,000) and Chittagong (336,000), perhaps taken on a tour of a jute mill, and at the end of two days are told that they have "seen" East Pakistan. Nothing could be further from the truth. Whoever has not seen the villages has not seen East Pakistan; because East Pakistan is first and foremost a collection of villages. Ninety per cent of the 50,000,000 people live in the villages and depend on the soil directly for their livelihood.

One of the village hospitals conducted by the Medical Mission Sisters is located in the town of Mymensingh (pop. 70,000)—the county seat of what one might list as the largest district of East Pakistan — also called Mymensingh. (Pop. 7,091,906, area: 6,156 square miles, a little less than the State of New Jersey.) Saint Michael's hospital in Mymensingh village, though small (45 beds), forms a significant part of the facilities available for the whole Mymensingh District. There is a government hospital of 140 beds in Mymensingh town; a thirty-bed nursing home at Baromari in the Garo Hills, a large hospital in Mymensingh District, in a place called Mirzapur, and also a few dispensaries. There is a shortage of nurses here, as in the whole of Pakistan.

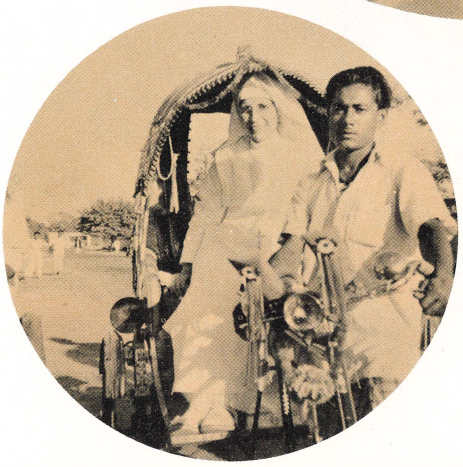
St. Michael's Hospital is about two blocks from the Brahmaputra River which arises in the mysterious mountain fastness of Tibet and winds its 1,680 mile course to join the Ganges before it empties into the Bay of Bengal. Our hospital was begun in 1948 by Sister M. Benedict (now Mother M. Benedict, Pro-provincial of the American Pro-province), in the turmoil that followed the partition of India and left the east branch of Pakistan separated from the west wing by 1,200 miles of intervening Indian territory. Under her skillful hands the hospital became known throughout East Pakistan. In witness of this I will tell you that in 1957 a telegram was sent to "Sister Benedict's Hospital—East Pakistan"; without hesitation the P.&T. Department delivered it to St. Michael's Hospital, even though at that time Sister M. Benedict had just completed a new and more modern hospital in Dacca, and was practicing her profession in that city.

One of the chief medical problems in Mymensingh is the quite natural fact that people are not used to coming to hospitals at all, thinking they are places to die in. Thus, they help to fortify this sinister reputation by bringing their patients only when all other resources have been exhausted, including the patient's will to live. After his vitality has been depleted by senseless and useless remedies, from black magic to homeopathy, he looks forward to death as a blessed relief from his misery. To cure a patient in this condition is a

Eye complaints are numerous. Trachoma is common. It is an inflammatory disease of the conjunctiva that eventually causes blindness. Many Bengali doctors are skillful eye surgeons.

Traveling around the village by jeep and on foot to patients unable to come to her—Mother M. Benedict gradually overcame the peoples' fears and superstitions. One in every five patients she found had peptic ulcers.

Scalpel in hand, Mother M. Benedict begins surgery in her jungle operating room in Mymensingh. There is much surgery—plastic surgery included.



Sister M. Christine (in bicycle-rickshaw) has spent the last six years practicing surgery in Holy Family Hospital, Dacca, the capital city of East Pakistan.

rare achievement, but one which immediately sets up the doctor's reputation as a miracle worker, and soon a procession of the halt, the lame and the blind is seen at his (or her) door. The most difficult decision is not "What is the diagnosis?" but "Which of this patient's many diseases shall I treat first?" A frontal assault on all of them at once upsets a subtle balance of power among them with which the patient seems to have set up "peaceful coexistence." Too much treatment can be just as fatal as too little.

Malnutrition is a generalized killer in an economy threatened by both flood and drought. The average weight of an adult is 80 pounds! A survey of the diet of the refugees showed an intake of 800 calories per day. Most of the people live on a subsistence diet, with no reserve of energy to fight disease, nor to better themselves. Good food is the medicine they most desperately need. Powdered milk doses with vitamins works wonders, especially in the children.

Malaria is a killer of young and old, and in a latent stage is ready to pounce on even the apparently healthy the minute they are laid low by accident, surgery or delivery. Malignant forms of malaria are common in Mymensingh. with the patient raging delirious, with fever of 105° to 108° F, and no ice! The kerosene refrigerator refuses to produce it in summer.

Neglected delivery cases are perhaps the most heart-rending, as both mother and baby could have been saved *if only* they had brought the patient sooner. Delivery cases are in the hands of the *dais* (untrained midwives) who refuse to admit defeat until after the poor woman has been in labor for three or four days. Often it is not ignorance nor poverty that condemns these poor mothers to the barbaric care of the *dais*, but stubborn adherence to age-old custom that says the first child must be born in the grandmother's house. Sister Perpetua had a patient whom she treated for sterility—a real curse in a land where no woman is a success until she presents her husband with a son. The woman in due time became pregnant. She was brought back to the hospital after she had been in labor a whole week, and was hopelessly infected by the unwashed hands of the *dais*. The baby was already dead, and the mother died shortly after she came to the hospital. This baby was certainly wanted. The family was not poor. They knew of the existence of the hospital. Why did they not come earlier? "It is not our custom for the son and heir to be born in a hospital."

Third killer here is "kala-azar" which literally means "black fever," (not to be confused with "black water fever," a variation of malignant malaria). It is characterized by high fever, and gradual enlargement of the spleen, leading to anemia, ascites and death. Though it may take many years to reach this term, its progress is inexorable. Injections of antimony compounds relieve a current attack, but whether they alter the course of the disease is hard to say. In this disease, as in many others (notably tuberculosis), as soon as the patient feels improved, he leaves the hospital, heedless of your admonitions to continue the treatment until absolute cure is achieved. You do not see him again until he has a relapse. This process goes on until the infective agent becomes resistent to the medicine because of the interrupted treatment, and the disease proceeds to a fatal termination.

W.H.O. has estimated the prevalence of leprosy in East Pakistan at: two or three per thousand of the population. Mymensingh certainly has its share.

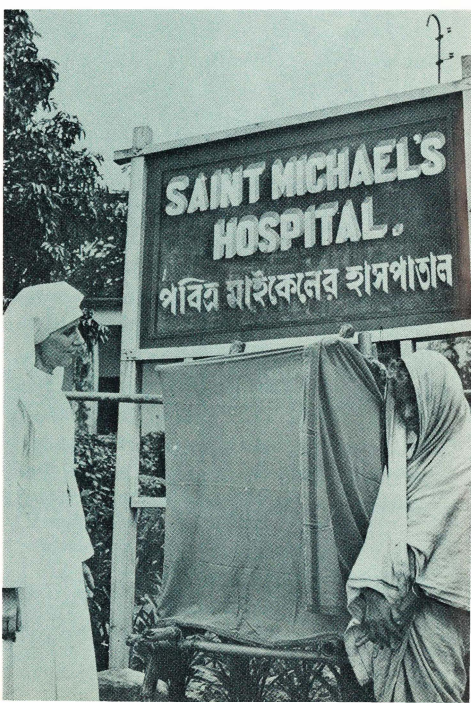
Sr. M. Lourdes treats tubercular baby. 90,000 die of T.B. every year—men, women, children, babies. It claims 10 lives every hour! Families living in one-room huts can't practice isolation.

They can be treated with modern drugs on an out-patient basis, but because of the age-old stigma attached to the disease (despite the fact that it is actually far less contagious than tuberculosis), many patients do not present themselves for treatment until the disease has caused irreversible damage to face, fingers, toes and nerves. Again, they stop treatment when they like, and few persevere the two to three years needed for complete "arrest." For the more advanced cases there is Our Lady of Mercy Leprosarium at Jalchatra, conducted by the Marianite Sisters of the Holy Cross about ten miles out of Mymensingh town.

Acute infectious diseases relegated to textbooks in more advanced countries by public health measures are rampant here. For example, in the epidemic year of March 1957-March 1958, 15.000 died of Smallpox and 10,000 died of Cholera in East Pakistan. Whole villages in Mymensingh District were wiped out. Typhoid is so common and so virulent that even scrupulous care of the drinking water and faithfulness to innoculation does not give 100% protection. The water supply and sewerage disposal (meaning the utter lack of proper facilities for either) account also for infectious hepatitis, polio, and a whole lot more. To test the water supply the health officer takes a deep sniff of a sample. If his olfactory endings are not horribly offended, he pronounces the water suitable for human consumption.

There is an endless supply of cases for plastic surgery—hare lips, cleft palates (unusually common), burn contractures, horrible deformities from

Sister M. Teresita greets Muslim woman patient who arrived in a covered palkey, carried by four poles. Muslim women must keep purdah.



obstructed delivery cases (provided the mother survives the ordeal) and blemishes of the skin (moles, birthmarks, etc.). These may not sound serious to you, but here a girl's fortune is really in her face, and an ugly face means an unfavorable marriage (i.e. to be a second wife, or married to an old man).

And what shall I say of the multiple faces of T.B.? Here is an infant in convulsions and coma—T.B. meningitis. Here is a young child with a crumpled spine—T.B. bone. Here is a young mother with a bloated abdomen filled with fluid—T.B. peritonitis. Here is a 40-year-old woman, in constant pain, and having repeated diarrhea—T.B. enteritis. Here is a young father, burning with fever, racked with cough and spitting blood—the old fashioned "galloping consumption" which claims 10 lives every day in Mymensingh. In the whole district, there is not a single hospital bed for segregation of infectious cases, and no T.B. clinics as such (though all the dispensaries treat them as out-patients). In a small hospital like St. Michael's, it is impossible to accept "open" cases, so we can only recommend home treatment, and hope that they will follow our advice. There is no visiting nurses' service to follow them up. How can they practice isolation in a one-room hut? How can they keep their dishes separate when the family owns one pot from which all take their portion? Can you advise them to drink plenty of milk when you know they can't afford it, and also that most of the cows are also tuberculous?

Intestinal worms are so universal a complaint that they are accepted as a part of normal living, and some patients worry that they can't survive without their "pets." Skin rashes are innumerable, and it is amazing how many of them can be cured by soap and water. Not that the Bengalis want to be dirty. They are forever taking a *snan* (bath). It's just that they can't afford a bar of soap, and pond water is ineffective against the many layers of coconut or pumpkin oil that have been zealously applied daily since birth.

Eye complaints are numerous. Trachoma is common. It is an inflammatory disease of the conjunctiva that eventually causes blindness, either because the lids become adherent to the globe (and hence can't be opened or closed) or secondary ulcers of the cornea destroy its clearness. 30,000 cataracts develop each year. No one has really investigated the reason for this frequency. Many Bengali doctors are skillful eye surgeons, and the treatment of eye diseases is more advanced than any other specialty (though still nowhere near the need).

Since St. Michael's has a woman surgeon, of whom there is exactly one in all of Mymensingh District, operations for conditions commonly called "female complaints" head the list. Muslim women are kept strictly secluded. (This custom is breaking down in the big cities, but still kept in the outlying dis-

Severe malnutrition accounts for many deaths. Average adult weighs 80 lbs.!

tricts). She will never, never, never consult a male doctor for any disease. The husband makes a list of her complaints (in great detail) and shows it to the doctor. From this he is supposed to make a diagnosis and prescribe a cure. But if the treatment should call for surgery, and there is only a male doctor available, then there is no cure, and the poor woman must drag through her days as best she can in constant misery.

The second most common disease requiring surgery is that of intractable peptic ulcers. While in America it is considered the bane of the executive under high pressure, here it is the farmer in his mid-thirties who comes, literally doubled up with pain. No x-ray is needed, even if it were available. They just don't come to the hospital until surgery is imperative.

The damp climate of Mymensingh favors the development of sinus conditions and rheumatic complaints (rainfall 91 inches per year; humidity usually 90-100%). Of course, these diseases do not kill, but they certainly make life miserable, and the task of daily hard work for subsistence wages almost unbearable.

Tetanus (lockjaw), snake bite, mauling by a tiger, rabies—any and every sort of emergency can come in, too varied and numerous to detail. Most cases are hopeless when we see them because of delay owing to the poor means of transportation. Cancer is also seen, but rarely before the incurable stage. No cancer society here to encourage people to consult their doctor at the first suspicious symptom.

Such a parade of human misery is the daily routine at St. Michael's hospital. We do what we can, and try to close our eyes to the millions we cannot possibly hope to help with our meager resources. The Government, aided by WHO, CARE, ICA and other philanthropic agencies, is making heroic efforts to raise the general standard of living and establish basic public health control. But there is no army of workers available to reach the numerous isolated villages, so progress is slow. Our efforts may be quantitatively small, but are a notable contribution because of the special problem of the Muslim women.

Mosque in Mymensingh. Most East Pakistanis are Muslims—35 million out of 50 million.

ত্রয়োবিংশ
তাঁর পোপ-
লক্ষে সাধু
ভেম্বর পরম
য় খ্রীষ্টযাগ
তিনি পরম
দর নিকট
শান্তির জন্য
নায়। তিনি
নর শত বর্ষ
ও মৃত্যুবরণ
ত্যু বার্ষিকী
পত্র লিখবেন

াল মণ্টিনীও
ধু পিতরের
ষ্টযাগ অর্পণ
ন পোপ পদে
কেই সর্বপ্রথম
সেদিনের
র উপস্থিত
া ত্রয়োবিংশ
বোন এবং
বন্দ।

লিওর মহত্ব বাস্তবিকই উচ্চ প্রশংশিত। সাধু পিতরের প্রৈরিতিক আসনে যে সকল পোপ অধিষ্ঠীত হয়েছেন সেই মহান পোপ মহোদয়গণের মধ্যে তিনি ছিলেন অন্যতম শ্রেষ্ঠ। তাঁর মহান গুণাবলী ও বৈশিষ্ট এমনই মহান যে তাঁর উত্তরাধিকারীগণ তাঁর এই কার্যকলাপ দেখে অবাক বিস্ময়ে স্তব্ধ হয়ে যান।"

২৫ শে নভেম্বর হলো পরম পিতার ৮০তম জন্ম বার্ষিকী। তিনি বলেন যে তাঁর পরিবারের প্রায় সকলেই দীর্ঘ কাল বেঁচে থাকেন, দীর্ঘায়ু যেন তারা পরাম্পরাগত ভাবে পেয়ে আসছেন।

পরম পিতা এ প্রসঙ্গে বলেন, "ঈশ্বর আমাদের যে দীর্ঘায়ু দান করেছেন তার একটি বিষেশ কারণ আছে। আমরা যেন আজীবন তাঁর বিশ্বস্ত সেবক হয়ে থাকি এবং প্রভুর ইচ্ছা মত যেন আমরা জীবন যাপন করি এবং সর্বদা যেন আমরা ঈশ্বরের কৃপা ও অনুগ্রহ লাভ করতে পারি।"

দেখতে জনতায় ভরে উঠে মন্দিরের প্রাঙ্গন।

ঠিক চারটায় শোভাযাত্রা বেরিয়ে পড়ে চ
সদর রাস্তায়। তেজগাঁ, নারায়ণগঞ্জ, তুমিলিয়া, ন
রাঙ্গামাটিয়া প্রভৃতি মিশন থেকেও খ্রীষ্টভক্তগণ
শোভাযাত্রায় যোগদান করে। ধীরে ধীরে এ
চলে সারিবদ্ধ জনতা। সামনে ক্রুশ ও মো
হাতে ছেলেরা। তার পেছনে রং বেরঙের
পরিহিত ছোট বড়, মেয়ে পুরুষের দীর্ঘ
প্রত্যেকের হাতে জপমালা। মিছিলের মা
উড়ছে পতাকা। বিশপ গাঙ্গুলী বহন করে
প্রভুর শরীর। তাঁর সামনে স্বর্গীয় চ
ছোট ছোট মেয়েরা ছড়াইছে ফুলের
সুগন্ধির ধূপদানি হতে ভেসে আসছে

৬ষ্ঠ পৃ : দ্রঃ

নিয়োগ

আর্চবিশপ ভবন,

১০ই নভেম্বর, ১

১। মাননীয় ফাদার চ
এস. সি., ভিকার জেনারেলে
গ্রহণ করেছেন। এ ছাড়
প্রদেশের কোষাধ্যক্ষ পদে
গর্ভাগমন ধর্মপল্লীর প্রধা
হয়েছেন।

২। মাননীয় ফাদার
ঢাকার পবিত্র ক্রুশ সং
নিযুক্ত হয়েছেন। তি
করবেন।

মহামান্য আর্চবিশ

ক্যাথিড্রাল প্রেসে পাওয়া যায়

১। খ্রীষ্টীয় পঞ্জিকা—১৯৬২ সন।
২। যীশু চরিত—মূল্য ২·০০ (দুই টাকা)
৩। বড়দিনের কার্ড মূল্য—১২ পয়সা
পঞ্জিকা—ইংরেজি ও বাংলা মাসের
ণের পর্ব সম্বলিত ছোট বইয়ের
মর্জিত ভাষায়

RACHEL VAN METER

The author spent seven years working as a missionary in East Pakistan.

BENGALI LANGUAGE

IN the remote centuries of India's mystic past, there was introduced to the subcontinent of Asia a language related to the tongues of Europe. The invaders who brought it were related to the tribes of Europe and all of their languages descended from a common ancestor which we call Indo-Europeans. Spoken languages are not frozen into permanent forms. In time, the Indo-Aryan speech of the invaders began to show marked changes. During the millenium before Christ the literature of India was employing a form of Indo-Aryan called Sanskrit. During the following centuries Sanskrit became the great literary medium for the sacred writings of the Hindus and as such was preserved in a "frozen" form. The language spoken by the people, however, was undergoing continual change and it eventually began to show local variations. These local variations became the basis for the modern vernaculars of the Asian subcontinent in the course of the language evolution.

Within a thousand years after Christ, a dialect distinct from other Indian vernaculars was being spoken in the northeastern section of the country. Many years later the geographical area became known as Bengal and the language emerging from the local dialect was called Bengali. Known to its inhabitants as "golden Bengal," the province has in some way lent its golden touch to the language. Bengal is no doubt the most beautiful section of the great plains of north India and Pakistan. A country of flowers, fertile fields, broad rivers and small canals, it seems very fitting that the language of Bengal should be soft, smooth-flowing and expressive.

To most westerners the name Bengali is either entirely unknown, or it is vaguely associated with some exotic tongue of uncertain location and little importance. Bengali gains some significance for us when we consider that it is the "mother tongue" of nearly eighty million people. It ranks with English, Chinese, French, Spanish and Russian as one of the great languages of the world in terms of first languages. Indeed, of all of the tongues of the subcontinent, including the much more familiar Hindi and Urdu, it is spoken by more people as their first language than any other. In recent years it has become an international language. With the partition of India, Bengal was divided between India and Pakistan—East Bengal became the Muslim state of East Pakistan; West Bengal remained with India.

In West Pakistan the acceptability of Urdu as the official language, after independence, added to its geographical compactness. However, the situation in East Pakistan 1,100 miles away from the mainland was altogether different. Here, where the majority of the Pakistani population lives, Bengali is spoken and used in daily transaction. Bengali, therefore, was declared a state language along with Urdu.

The Bengali of East Pakistan is not exactly the same as that in vogue in West Bengal, India. Bengali here has been somewhat modified and made "Islamic" by Pakistani writers and journalists. One could say the difference between Indian-Bengali and East Pakistani-Bengali is like that between British English and American English.

Spoken Bengali sounds very different, indeed, than any of the languages of the west. One of the unique features of its sound system (a feature to be found in nearly all Indian vernaculars), is a meaningful contrast of aspirated and non-aspirated stops. This feature is a source of very real grief

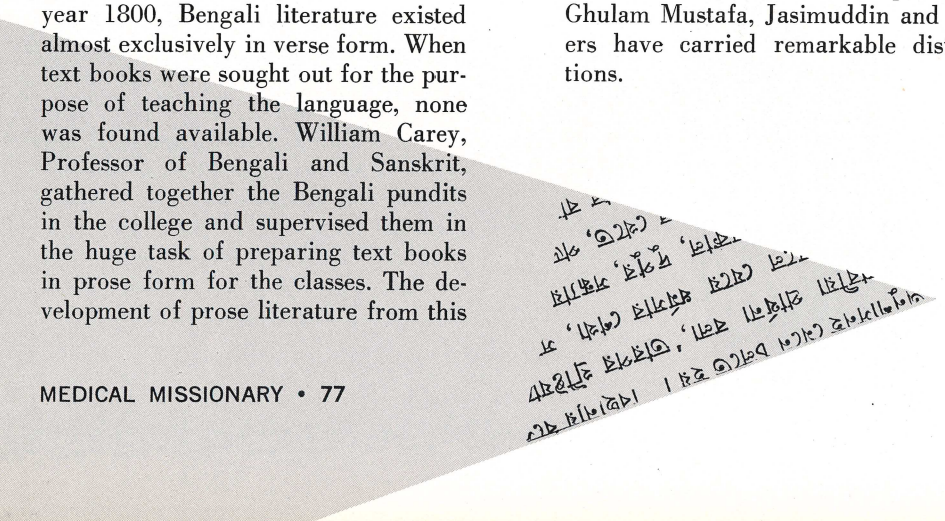
to westerners learning the language. It is exceedingly difficult for westerners without training to hear the difference in these contrasting sounds and practically impossible to reproduce them. After having at least partially conquered this problem, one is faced with the problem of associating the correct meaning to words of identical spelling and pronunciation, with the exception of the spirations feature. How does one keep straight words like *kabar* and *khabar*? One means a grave; the other means news. It is necessary to resort to the sort of imaginative association suggested by one language teacher who advised her English speaking students to remember that there is no breath in the grave!

The literature of the Bengali language is, in fact, one of the important literatures of Asia. Prior to the nineteenth century, Bengali poets composed some very admirable poetry. It was during this period that Portuguese missionaries in Bengal became the first Europeans known to have studied and to have written in the language. By the year 1800 the British East India Company had realized the necessity for training its servants in the local languages and culture, and with this aim in view established the College of Fort William in Calcutta.

From the College at Fort William issued forth the first prose literature to be written in Bengali. Prior to the year 1800, Bengali literature existed almost exclusively in verse form. When text books were sought out for the purpose of teaching the language, none was found available. William Carey, Professor of Bengali and Sanskrit, gathered together the Bengali pundits in the college and supervised them in the huge task of preparing text books in prose form for the classes. The development of prose literature from this humble beginning throughout the nineteenth century is truly remarkable. This literary renaissance period produced such great names as Ram Mohan Ray, Iswarchandra Vidyasagar, Bankimchandra Chatterji, Saratchandra Chatterji, etc.

The impact of Western thought upon the Indo-Pakistan subcontinent in the nineteenth century ushered in a new phase in the history of Bengali literature to which also East Pakistan made a very considerable contribution. Michael Dutt, author of the best epic in Bengali and creator of Bengali blank-verse, belonged to Jessore. Nabin Sen, another well-known poet, was also an East Pakistani. Of the Muslim authors of this period the most renowned is Kaikobad who wrote an eight-hundred-page epic poem on the downfall of the Moghul empire. Mir Musharraf Hussain, one of Kaikobad's contemporaries, produced a prose masterpiece dealing with the tragedy of Karbala.

It was really in the 1920's that the new trend in Muslim Bengali literature was begun. The famous poet Qazi Nazrul Islam developed a style of language in which Muslims found expression. It grew into the literary medium now known as Musalmani Bengali. Since the days of Nazrul Islam a new Muslim literature has sprung up and with partition has flourished even more. In recent years the Muslim poets of East Pakistan—Sofia Kamal, Faruq Ahmed, Ghulam Mustafa, Jasimuddin and others have carried remarkable distinctions.



CUSTOMS & COSTUMES

SISTER M. THOMAS

HOW times change! Often in my musings I think of the Bengal of years ago and the Bengal of today. Take for instance the purdah women, their customs and costumes.

On arriving in Karachi, West Pakistan in 1957, after a lapse of ten years in America, I was astonished to see so many Muslim women on the streets. True, they wore *burkhas*, but what beautiful ones: lovely shades of navy blue, brown, dark green and lighter shades of strawberry and tan, all made of costly taffeta material. The styles, too, were very modern. Either a long sleeveless jumper gown or a gathered skirt, topped by a cape and hood with a little flap in front, extending from the forehead to the chin. This was raised quite frequently for taking in the sights as well as for the right direction.

Back in the 1940's in Bengal, especially in Dacca, a few of the high class purdah women were driven through the streets in cars with the windows heavily curtained, or in tongas with screened windows. Very few, if any, women were ever seen walking the streets. It was truly a man's town.

At the Welfare Center where Sister M. Francis (Herb) who has long since gone to her eternal reward, and I worked 10 years ago, there was only one *burkha* in the midst of ten or fifteen *bari* folk. The little mud huts in which the people live are called *baris* and the people, *lok*.

To go back to the *burkhas,* which were always white and made of cotton material in those days always reminded me of a Hallowe'en costume. A long, loose gown extending from head to ankles. The head piece was hood-shaped with holes cut out for the eyes and mouth. These holes were screened with meshed material. There were slits in the upper part of the gown used as an outlet for the arms and hands.

One woman waited for the other to return home so that they, in their turn, could make their call to our dispensaries. Who really owned the *burkha* was a mystery.

Today in Mymensingh, East Pakistan, the majority of Muslim women come without a *burkha* to the dispensary. In fact, purdah means very little if anything to them. They stand side by side with the menfolk awaiting their turn to visit the doctor and to obtain their prescribed medicines. Formerly, they had to have a separate dispensary for these women. A few of the better class Muslim women come in purdah costumes of the newer fashion.

A few days ago, two of our Sisters went to visit a former patient at her *bari* which is located in New Colony. This is a section of the town where a great many of the employees of the railway live. In America we would call them middle-class.

In passing through, the Sisters met four women in *burkhas*. The oldest of them was probably about thirty years of age and was acting no doubt as chaperone. Although in purdah they went along very merrily and even stopped to ask the Sisters if they would not come to the movies with them. One could scarcely imagine anything like this fifteen years ago.

In our hospital wards today, Christians, Muslims, and Hindus are not segregated but lie in beds side by side. They converse with one another and seem very happy.

It will probably be many years before purdah has been completely abolished, if ever, but it certainly has lost much of its iron rigidity.

Another most interesting change throughout the years is that seen in the care of maternity cases. In the days gone by, it was very difficult to prevail upon the family to bring the patient to the hospital, even if she were in a most critical condition.

At the first sign of labor the mother was conducted to an outside shed, dirty, drab and airless, or to some screened off partition of the house. Here she was doomed to remain for thirty days, and was considered unclean. This was chiefly Hindu custom but many of the poor Muslims were no better off.

After delivery a fire was kept smoldering to keep the evil one away from the new-born child. The child was made hideous with black markings because the evil one took beautiful babies. This custom continues to the present day, for many are still superstitious.

When visiting these patients we were not allowed to pass through the house but were directed to go to the side or rear entrance which was always a muddy alley or gully.

Before leaving the house the children were carefully sheltered lest we should touch them and contaminate them. Our footprints were cleansed with water and strewn over with cow dung. You can well imagine that they were not too

happy for us to come. But this is the work which the Municipality had employed us to do, and we were happy to do it.

We endeavored to bring a little cleanliness to them by using pads made of old saris and paper for the mothers to lie on. Also sterile instruments and cord ties for them. The *dhais* (native midwives) in our classes and the midwives employed were also instructed to do the same.

Nowadays many of the women come to the hospital for delivery. A considerable number of fond husbands haunt the place until after delivery. They are eager to approach their wives as soon after delivery as possible and to look upon their new-born child.

So gradually the mothers are being instructed in cleanliness. The husbands are shown the advantages of hospital care and in many cases are willing to cooperate. Times have changed for the better!

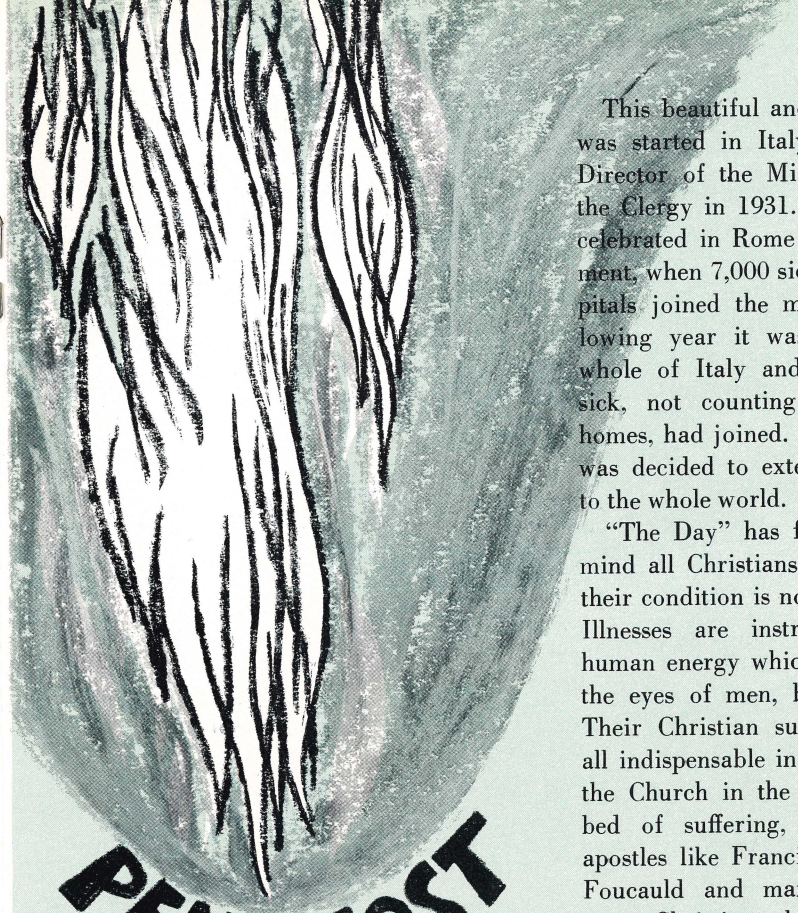
Muslim woman in new-style burkha lifts her veil as she speaks to Sister-doctor. Muslim women must veil their faces in the presence of men.

YOUR WILL

can help the Medical Mission Sisters bring health and healing to the sick and suffering of mission lands. The following approved form of bequest may be used:

"I hereby give (devise) and bequeath to the Society of Catholic Medical Missionaries (also known as the Medical Mission Sisters), an institution incorporated under the laws of the State of Maryland, and its successors forever the sum of $..... for its purposes,"

If you have already made your will, it is not necessary to make a new one. It is sufficient that a codicil be added, using the above.



PENTECOST MISSION SUNDAY FOR THE SICK

REMIGIO MUSARAGNO

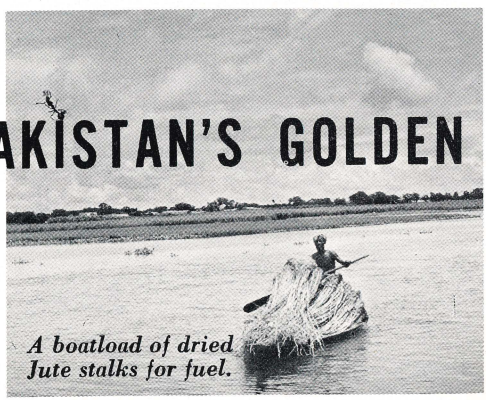
WORLD Mission Day of the Sick, which yearly is celebrated on Pentecost Sunday, has for its aim to invite the sick to change into an altar of holocaust their bed of suffering. There are in fact, no prayers which are heard more speedily than those which draw their constancy and force from suffering.

This beautiful and holy Association was started in Italy by the National Director of the Missionary Union of the Clergy in 1931. The first day was celebrated in Rome by way of experiment, when 7,000 sick of the city's hospitals joined the movement. The following year it was extended to the whole of Italy and by then 200,000 sick, not counting those in private homes, had joined. In April of 1934 it was decided to extend this movement to the whole world.

"The Day" has for its scope to remind all Christians who are sick that their condition is not one of inactivity. Illnesses are instruments of superhuman energy which are hidden from the eyes of men, but not from God. Their Christian sufferings are above all indispensable in the building up of the Church in the world. From their bed of suffering, they can become apostles like Francis Xavier, Massaia, Foucauld and many others because every Christian who unites himself to the sufferings of Christ and makes them his own becomes a mystical Christ. The work of the Redemption of Christ continues in this way without interruption.

In the missionary prayers of the sick the application particularly impressive of a sublime law of supernatural life, and of the apostolate, is seen; "infirma mundi elegit Deus." *God chooses the weak of this world. . . .* It is a beautiful task to seek to overcome with the energy that issues from the merits of those who suffer in body, in apparent weakness, the immense difficulties which the missionary apostolate encounters in the conversion of the world and the spreading of the Church.

Farmer sowing the Jute seed in the field.



A boatload of dried Jute stalks for fuel.

PAKISTAN'S GOLDEN FIBER

JUTE

SISTER M. LOURDES

Gathering cut Jute stalks for soaking.

Known as the "golden fiber," jute is the most important non-food crop of Pakistan. Despite the fact that for many years Americans as well as other people of the western world have walked on jute, sat on jute, and slept on jute, not many people know where it comes from. It's most obvious use is in sacks and sackcloth, but jute has a thousand other uses. Carpets are usually woven on a base of jute; linoleum is built upon a base of jute. Pakistan and India together hold a virtual monopoly of the world's jute. Pakistan accounts for 75% of the world's jute production on the sub-continent.

EAST Pakistan's economy practically revolves around jute. It is this golden fiber which provides the people of that province with the means of their livelihood and their lifeblood. In 1947 when the sub-continent of India was divided into India and Pakistan the provinces of East Pakistan found themselves still the leading jute producing area of the world, but without the mills needed to convert their raw jute into processed goods. Previously, all the raw jute raised in this area, which is now East Pakistan had been feeding the mills of Calcutta, now part of India. Today in East Pakistan seven or eight 1,000-loom mills convert this golden fiber into burlap, bringing in 40-45% of the total foreign exchange. The funds for these mills were provided by the Pakistan Industrial Development Corporation (PIDC) as well as private industrialists.

The story of jute before it reaches the mill is one of great human interest because it involves the lives of men, women and children. Farming is a family affair in Bengal. The jute field is usually owned by several brothers who have inherited the land from their father. In turn each will leave his small share to his sons and with each generation the inheritance becomes smaller and smaller. Each brother lives in a one-room bamboo hut with his wife and children. Instead of straight city blocks these *bashas* are arranged in a circle and create a closely knit unit known as a *bari.* Ninety percent of the people of East Pakistan are engaged in agriculture and live in this manner. This is the core of the nation and the heart of the story.

August is hot in Bengal. The humidity is 95% and the temperature 105°. It is also harvest time for the jute-raising farmers. Armed with a sickle-like tool, the men and women of a *bari* cut down the jute stalk when it is about six feet high. Jute, like rice, requires a large amount of water. In this area the rainfall averages 100 inches per year. Primitive irrigating facilities necessitate back-breaking hours in the sun and a late monsoon can ruin the crop completely.

Often the harvesters stand ankle-deep in mud ten to twelve hours a day for a week or more until the harvesting is done—every inch by hand. At the end of the day the stalks are carried from the field to the nearest *pushkarini,* or man-made reservoir, to soak for days. Rotting jute is everywhere during the months of August and September. After four weeks the stalks are removed from the water and again the whole *bari* turns out for work. This time even the smallest child can be kept occupied.

In waist-high water, the men haul the stalks to land where the women are waiting to receive them. Even with a baby on one hip they manage to haul away a good bit of this now soft, rotten and dripping wet stalk. Seated in the broiling sun, protected only by the shade of a banana leaf, they begin the tedious task of stripping the fiber from the bark. Small children take their places behind adults as they sit or squat with their stalks in front of them. One's first impression is that of a Yale sculling team with oars poised.

The women, children and older men are constantly kept supplied with fresh stalks by some women who bring it from the *pushkarini.* The stripped bark is carried away and placed erect in the sun to dry like so many tents. These will be used at a later date to patch roofs, make baskets and be used as kindling for the fire. The fiber itself is gathered and hung on lines to dry. The little ones go about picking up

what has been missed, either fiber or bark, as every small scrap will be used.

The only thing that interrupts the process is a cloudburst and then everyone rushes to the lines to rescue the drying jute. This drying takes days and each delay means a longer wait for the day it can be loaded onto the bullock cart and taken to be sold.

The dusty road which passes in front of St. Michael's is a bullock cart path and the squeak of the wooden wheels is heard all night as cart after cart of the nation's leading export goes to be sold by the individual farmer. If you happen to be on night duty and see the lanterns swinging from the bottom of the cart as one by one they pass, you know that this means employment for many of the people of the country. It means money for the farmers and the reward of their labor. Debts can be met, a wedding arranged and school tuitions paid so that perhaps in years to come their children will find faster and less back-breaking means of harvesting this golden fiber.

From Mymensingh alone tons of jute, loaded onto trains by coolies, are carried to the mills of Naryanganj and Kulna. This is the leading industry and as it grows so do opportunities for the people of the country. Today the women leave the fields to prepare the family's first meal after long hours of work. Tomorrow there may be ways and means of lessening their burden and increasing their comforts.

Jute Mill—Making burlap bags. From Mymensingh alone, tons of Jute, loaded onto trains by coolies, are carried to the mills of Narayanganj.

Please pray for our benefactors recently deceased:

Aloisius Cardinal Muench, Fargo, North Dakota
Rev. Robt. J. Sheehan, C.S.C., Notre Dame, Indiana
Bro. Fermin-A. Rheaume, C.S.C., Montreal, Canada
Bro. Herbert Morrow, C.S.C., Washington, D.C.
Bro. Liborius (Stanislaus) Lane, C.S.C., Notre Dame, Indiana
Mother Mary of the Angels, O.C.D., Manchester, England
Miss Ellen G. Clune, Norwich, Conn.
Mrs. Sarah Hargrove, Camden, N. J.
Mrs. Julia Harvey, Phila., Pa. (MMS Aux.)
Dr. Frederick C. Hutton, Bustleton, Pa.
Mr. Peter Kershbaumer, Hazleton, Pa. (Father of Sr. DeMontfort, S.C.M.M.)
Mrs. Anna Minj, Bihar, India (Mother of Sr. M. F. Alphonsa, S.C.M.M.)
Mr. Joseph Neuman, Cincinnati, Ohio
Mrs. Anna Owens, Massapequa Park, N. Y.
Mrs. George Sullivan, Santa Clara, Calif.
Miss Mary Toland, Phila., Pa.

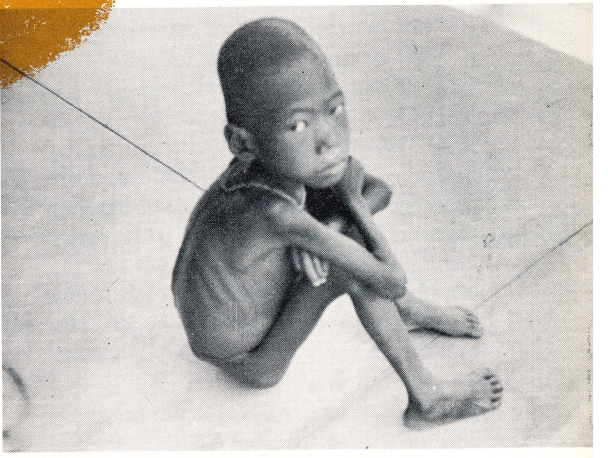
The Medical Mission Sisters have as their apostolate the care of the sick in those parts of the world where the need is greatest. Theirs is a vocation that calls for a large measure of generosity from each individual Sister as she brings healing and hope to the people of India, Ghana, East and West Pakistan, Venezuela, and South Vietnam. Her task, whether as surgeon, nurse, pharmacist, technician, hospital housekeeper or secretary is one of bringing Christ's love to men in a tangible way through the action of her hands and the devotedness of her life thus making real the joyous measure of salvation.

TIRONI

SISTER M. CLAUDE, M.D.

A MOST interesting, yet treacherous parasite with whom most medical practitioners develop no more than a text book acquaintance, has been a thorn in the side of many a physician here in Bengal. His presence in this area was felt about one hundred years ago and, from that time until the present, he has visited many homes and brought misery and sadness to many families. In scientific circles this parasite is called Leishmania, a microscopic protozoal organism who spends a part of his life in a sandfly. The sandfly, an inhabitant of Bengal and other parts of Asia and Africa can transmit the organism into the human blood stream where it prefers to live and flourishes in the liver, spleen and lymph nodes. Here it quickly produces generations of its progeny, and while doing so the symptoms of fever, anemia, enlargement of the spleen, and emaciation begin to manifest themselves. Perhaps it is because the sandfly is a low-flying insect, that children seem to be the most susceptible, and their healthy bodies are transformed into a wasted form with spindly arms and legs; and a bloated abdomen filled with a spleen often enlarged five times its normal size; and a typical darkened complexion which is responsible for the name of the disease: Kala Azar or Black Fever.

There have been many Pakistanis of all ages and stages of the disease in the Out-Patient Department and the hospital, some of whom have gone home relieved after a course of Antimony injections, rest, good food and vitamins. Others have come in the last stages of the disease when their swollen severely anemic and malnourished



Tironi Anna, five years old, when she was brought to St. Michael's Hospital—wasted body, enlarged abdomen, no hair, spindly legs and arms, darkened complexion diagnosis—Kala Azar or Black Fever.

bodies have not responded to any form of treatment.

In this part of the country where the disease is endemic it ranks close to tuberculosis as one of the leading health problems. Like Tuberculosis it often progresses slowly eating up every trace of physical and spiritual beauty as it proceeds.

Take Tironi for instance. Tironi Anna was entered in our medical annals at an estimated age of five years. I might add, that age is a matter of no concern here in Mymensingh. A seventy year old woman is just as liable to tell you that she is 25 years, married 20 years with 7 children, the youngest of which is 19 years, as she is to say, "Look at me and guess." In other words one quickly learns that any statement as to length of illness or age is a fallacious estimate on the part of one who has no conception of, or interest in, historical events.

At any rate Tironi Anna was brought to us from one of the outlying villages with the spark of life just barely visible behind her pallid listless features. One look at her wasted body and the enlarged abdomen that threw her off balance and gave her a peculiar waddling gait was enough to make the diagnosis of Kala Azar. Hers is no spectacular story nor does her gradual recovery spell out a miracle. As slowly as the closely cropped stubble on her head grew out to be hair so her physical health returned and with it the beauty and simplicity of her child-like soul manifested itself. Before our eyes she was transformed from a sullen, mute, disinterested creature into a laughing, fun-loving miniature adult, and with the transformation she won our hearts. She began to take pride in her appearance and had no idea that the big red ribbon which she tied around her almost bald head together with the gold earrings that dangled from her pierced ears made her look ridiculous rather than glamorous. She showed interest in hospital household tasks, and without much instruction became an expert cotton ball manufacturer. She wandered into the kitchen and helped prepare vegetables, or out into the garden where she proved to our amazement that she had a good knowledge of the difference between weeds and flowers. But with the usual impetuosity of a child her zeal for work left her when there was an opportunity to climb for mangos, and she was never happier than when she was extracting the last precious drop of juice from the flat mango pit.

But what about her Kala Azar? She still requires intermittent injections and treatment for several years to come. But for the time being, at least, she is able to function and live where she blongs—in that carefree joyous world of Childhood.

Tironi Anna, two years later, smiling her thanks for her recovery. She still comes back for injections and treatment.

BOOKS

THE CHURCH & THE WORLD

AND WE, THE PEOPLE. Rev. Tim O'Neill. N.Y. Kenedy. 248 pp. $4.50.

The title of this tale of missionary work in New Guinea comes from the name by which the primitive Mengen tribe is known. Father O'Neill spent seven years among these people and writes of their customs, folklore, struggles and joys with a perceptiveness and a quiet humor which matches their own wit.

WORLD CATHOLICISM TODAY. Joseph Folliet. Westminster, Md. Newman. 214 pp. $3.25.

Dr. Folliet's view of the Church in the world today is briefer than one could wish. Following a short chapter covering Church History, 1858 to 1958, he examines the special problems encountered by the Church in various geographical and sociological areas, Catholic Action, missionary activity, ecumenical movement, the spirituality of the modern world. If what he says is not new, compensation is to be found in the fact that Dr. Folliet has drawn together in a concise and highly readable book many facets of modern religious sociology.

THE ANTHILL. Suzanne Labin. N.Y. Praeger. 442 pp. $6.75.

Suzanne Labin, a French political analyst, went to Hong Kong—exit point for many refugees from Red China—to collect these eyewitness accounts of life in China under Communism. The results are impressive. Questioning many Chinese from all over China, and from every walk of life, she learned of conditions on the mainland, and the reasons for their flights. Lest the book give the impression that everyone is discontented under Communism, it is necessary to remember that only those who fled were interviewed. Though not all the book's conclusions have equal validity, it is a masterly compilation of source material.

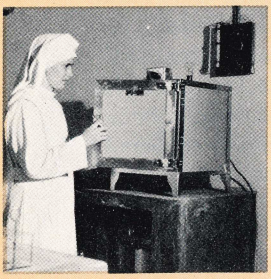
SOUTHEAST ASIA TODAY. Maryknoll, N.Y. Maryknoll Publications. 68 pp. $1.00.

INDIA TODAY. Maryknoll, N.Y. Maryknoll Publications. 52 pp. $1.00.

These looseleaf publications are a continuation of the World Family of Peoples series, meant as a classroom enrichment material for grade school geography courses. The second book includes Pakistan, Ceylon, Nepal and Bhutan as well as India. Both books include a collection of plates for use in making bulletin board displays.

SISTER M. FABIAN

EXPECTING THE UN-EXPECTED?



Sister M. Terence, R.M.T.

WHAT makes laboratory work in a village hospital in Mymensingh, East Pakistan different from the same work in a hospital at home? I'd say the biggest difference is the element of surprise—which, after all, keeps us on our toes and many times laughing, no matter what we do.

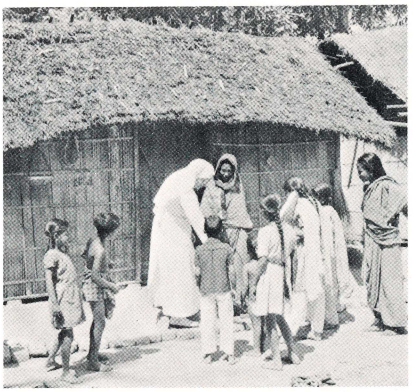
Where else would you find filaria thrashing around in a blood count, or malaria and Kala Azar parasites in a routine blood smear? Where else can you prove a microscopic diagnosis by the microscopic monster looking at you out of the specimen jar, as if to say, "Don't bother looking further . . ."

There is also boundless scope for research. For instance, in the Garo Hills to the north of Mymensingh, are a people who have settled in these low hills at the foot of the great Himalayas. These people, the Garos by name, are distinct racially from the people of Bengal. Now it is a common fact that human blood is human blood and granting that the blood types are the same, a difference in race should make no difference in blood compatibility. However, the Garos seem to be an exception to the rule and it is very rare that you can find someone of another race to cross match with them. We have a saying that only a Garo can give blood to a Garo. There is, of course, a reason for this which could be discovered by proper research.

The world of parasitology is also an enormous field and Rev. Richard Timm, C.S.C., of Notre Dame College, Dacca, has named some "never before known" plant parasites in East Pakistan.

Another challenge to the imagina-

SISTER M. TERENCE



Mother M. Benedict visits a former patient for whom she delivered two babies at St. Michael's Hospital. The patient was fine but one of the children had malaria.

tion is how to keep your human blood bank around the hospital if the patient should need more than one pint of blood. An ice box run on kerosene is not cold enough to store blood . . . so if doctor orders two pints today, one pint tomorrow, etc. you find two people today, one person tomorrow. The problem is how to keep today's donors from horrifying tomorrow's donor. In most cases everyone disappears into the "jungle".

Occasionally, though, you come across the patient with a flair for enterprise and opportunity. Such was the case of Subas, an eighteen year old Garo boy, who was admitted with Kalazar and a 3.0 gram hemoglobin. As it happened, he was a recent convert from one of our neighboring mission stations. The Father in charge of the Catechists' Training School across the road thought it would be a fine opportunity for practise if his students would enlighten Subas a little more on his religion while he was in the hospital. However, Subas was eyeing his instructors with a view to improving his health along with learning his catechism, and almost every session would end with a little sermon from the patient on a practical means of charity such as donating a pint of blood for a good cause.

He stayed with us long enough to make his First Holy Communion but has since returned to his village—not cured, but greatly improved on the blood donated by the Catechists.

In and around Mymensingh District there are other small labs but our one distinction seems to be that we have a generator and are able to do blood chemistries. This can be a little frustrating at times between keeping the animal life out of the generator and mold out of the reagents, but therein lies the element of surprise. Example: You turn on the colorimeter, the light starts blinking and the needle on the dial is running wild, you turn off the machine frantically, open it up—and out jumps a lizard (better known as tick-ticky) and you are happy that that's all that's wrong.

As times goes on you begin to expect the unexpected, but happily this doesn't diminish your capacity for enjoying each new "phenomena" as it comes along.

across the

INDIA

Eyes for the Blind

On New Year's Day, Dr. Caccamise of Rochester, N. Y. arrived with about everything necessary for the running of this three months' free eye clinic here at Kurji Holy Family Hospital. Sisters Adelaide and I met him at Patna airport. Doctor Caccamise has left his practice for three months in order to bring this aid to the blind of India, without personal remuneration. Last week I had the opportunity of assisting him with a corneal transplant. The procedure looked easy in his hands. The Rochester Eye Bank donated the corneas—twenty in all—plus ten bottles of human vitreous. Sutures were the gift of Davis and Geck Company and medications were given by Pfizer, Upjohn, Abbott, Burroughs Welcome, Armour, and other U. S. companies whom I hope will not feel slighted for not having been mentioned. These were very generous gifts to the blind of India.

The clinic is really crowded. An average of 70 to 90 patients are seen daily in the Out Patient Department and often as many as 50 more have to be turned away. Though the clinic opens at 8:30 a.m. the crowds begin to line up at 5 a.m., despite the bitter cold weather of this season. One of our resident doctors, and two graduate nurses, as well as students and aides are assigned full time to the eye clinic. In the afternoon, Doctor Caccamise does an average of ten operations daily, usually cataracts, though some are for

strabismus, glaucoma, ptosis, pterygiums, or eviscerations. Dozens of letters pour in daily from all parts of India, many of whom saw the news in the *American Reporter*, the USIS news weekly. Sadly though, many are beyond hope. But the 375 in-patients, already operated upon or treated medically, bear witness to the hopefulness of many conditions, seen in these first few weeks alone.

Sister M. Frederic, M.D., Kurji
Holy Family Hospital, Patna, India

GHANA

Adapting the Dance

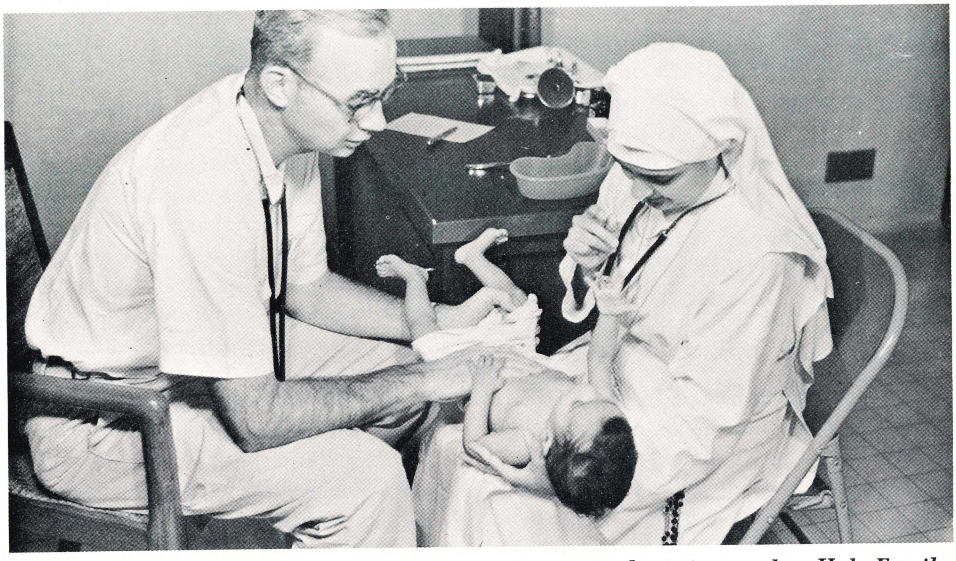
The entertainment was given right outside our vacation house in Teteman by the "Teteman Cantata"—a musical group sponsored by the parish. This Cantata has several purposes: to provide entertainment for various church and town festivals, to furnish a wholesome outlet for the young people, and to adapt local customs and talent to the Church's liturgy and teachings. Dancing is so natural to our Ghanian people—even the infants riding on their mothers' backs will beat time to their dancing and singing! So in the Corpus Christi procession, one of the highlights of the Church year here, the procession is led by dancing groups, joyously singing the praises of the Blessed Sacrament. In Teteman, only the dances led by the "Cantata" are approved for the religious festivals, but this can hardly be said to limit their scope! On the afternoon when they came to perform for us, the chairman of the group informed us that they planned to dance for about forty-five minutes—and after one-and-one-half hours, they finally noticed that the time was dancing on, too, and reluctantly terminated the performance!

We knew in advance that the Cantata would come that Sunday afternoon, and could hear their drumming and singing long before they came into view, stepping lightly over the mountain top. There were more than fifty of these young people—about forty of them girls, and the rest young men. The girls were dressed in the traditional Lagosian-style dress: round-necked blouse with short, full sleeves; and knee-length, sarong-like dress tied at the waist with a belt of the same material. All this is topped by a deftly twisted turban of gay, colorful material. They really looked lovely, and the ensemble is a very modest one. The Lagosian-style dress is not the usual one worn in Teteman except by Lagosian people themselves, but it was adopted by the Cantata as the best for dancing—being both modest and attractive. Before each number, a charming young woman announced the theme of the dance to us, and the dancers fell into line, making four rows in all.

Most of the themes were religious ones. For example, one song was entitled "Gloria in Excelsis Deo" and

these words of the Angels were repeated throughout the entire dance, sung in joyous rhythm while the dancers, in unison, "interpreted" what it meant with their rhythmic steps and graceful movements. Meanwhile six drummers kept up the lively beat, defying even the onlookers to keep their feet still in the midst of such enthusiasm! Then there was a dance about the Resurrection, another about the King David, several with themes from the Bible, and many that pointed out a religious moral. My favorite: "Herod was a Christian in name only, because he stole his brother's wife!" I wish that all the Sisters could have had the joy of witnessing the Teteman Cantata. It is a concrete example of the Church's aim of "adaptation," keeping what is good in the people's culture and sanctifying it.

Sister M. Theodore, Holy Family Hospital, Techiman, Ghana



Treating and training, two important aspects of his medical mission work at Holy Family Hospital, New Delhi, India. Here, Dr. Harry K. Purcell, former St. Louis surgeon, works closely with Sister-doctor M. Francis Lourdes of the Medical Mission Sisters, presently doing a surgical residency at Holy Family Hospital. This hospital in India's capital city is one of ten medical centers conducted by the Medical Mission Sisters in India.

FINAL VOWS, February 11, 1962

Sr. M. Benedicta Rowan (Maracaibo)
Sr. M. Brian Seydel (South Shields)
Sr. M. Francine Dean (Philadelphia)
Sr. Gabriella M. Erlich (Gelsenkirchen)
Sr. M. Kieran Foley (Rawalpindi)
Sr. M. Michelle Normand (Kurji)
Sr. M. Patrice McSweeney (Maracaibo)
Sr. M. Paul Bazinet (Philadelphia)
Sr. M. Phillip Hornung (Philadelphia)
Sr. M. Martha Heiser (1st. vows, Phila.)

FINAL VOWS, December 8, 1961, in Poona

Sr. M. Camillus Toppo
Sr. M.F. Gemma Mendes
Sr. M.F. Margaret Mendes
Sr. M.F. Joan Matheikal
(Kurji, Dec. 6, '61)

GERMANY

Pioneers Open Novitiate

In August, 1961 we moved into an old convent, belonging to a parish of a very industrial city, Gelsenkirchen, in the middle of the "coal pot," as they call the *Ruhrgebiet,* the biggest industrial center of Germany. The Sisters, who had lived here formerly, left on the same morning. And what a marvelous welcome we received from them! The beds were made, the table set and a perfect meal on the stove in the kitchen.

Mother Dengel returned here once more in December to see the prospects, and after her return to Rome, it was decided that we would start the Novitiate here. This was January. It surely did not leave us much time, but we started with sleeves rolled up and were surprised ourselves when all was ready for February 11th. One part of the building, which still houses a Kindergarten, run by lay personnel, had a huge sewing room upstairs, which we decided to convert into a Novitiate. This room had been used since August as a place where one just puts anything from boxes of medicines to new and old clothes, instruments, etc. So we packed, and sorted, and cleaned without stopping with great fun and excitement. The postulants (all nurses) helped. I don't think we would have finished without them.

A Sister Superior of a hospital, whom I met while buying material for the habits, sent us two beds, lockers, and an old kitchen cupboard, which now serves our postulants and Sister Gabriella Maria, their mistress. In the huge sewing room, we put up some big old cupboards for walls, painted the backs white, and drew some curtains between them. So now that is our new Novitiate. Sister M. Rupert was appointed Novice Mistress.

The Auxiliary Bishop came for the ceremony on the 11th, but we could not have a Pontifical Mass as our chapel is too small. The 11th itself was a glorious day with sunshine, which rarely happens. All the families of the postulants had come on the 10th, and so the chapel was filled. From the nearby hospital we borrowed a beautiful cope and the Bishop came with his own mitre and crozier. Everything looked so festive. Sister Gabriela's mother came all the way from Italy. One postulant's parents, a lovely Tirolese couple, came from the mountains of East Tirol—the longest journey they had ever made.

We had our simple clothing ceremony and afterwards, a German High Mass, that is, a Mass with German hymns—a privilege we have here. His Excellency Bishop Julius Angerhausen, who is very mission-minded and has been to Africa twice, spoke very simply and beautifully to all and gave them in his sermon the incident of Our Lord with His disciples—"Come and see." After the Mass, during which Sister Gabriela made her Final Vows, the Bishop very graciously met everyone.

Sister M. Monica was here from Rome at the time. Mother M. Michael and Sister M. Leonie came from Holland bringing a few more Sisters. The parish took a very active interest, sending flowers, food, etc.

All together it was a day of great joy and consolidation after the first year here. We hope that many such happy days will follow, and ask you to help us pray that the Lord may bless our beginning here for His Greater Honor and Glory and for a fruitful future missionary apostolate.

Sr. M. Jutta, Gelsenkirchen
Wilhelm-Buschstrasse 32,
W. Germany

February 11, 1962. Gelsenkirchen, Germany. Medical Mission Sisters held first Reception and Profession Ceremonies. Aux. Bishop Julius Angerhausen (Essen) presided. Three postulants received the religious habit, and Sr. M. Gabriella made her final vows.

THE MEDICAL MISSIONARY
8400 Pine Road, Fox Chase, Philadelphia 11, Pa.

Please enter my subscription to
THE MEDICAL MISSIONARY MAGAZINE FOR

1 Year $2.00
2 Years . . . $3.00
3 Years . . . $4.00
5 Years . . . $6.00

NAME_____

STREET_____

CITY_____ ZONE_____ STATE_____

The secret of our fulfillment then is charity. We bring to the Psalms the raw material of our own poor, isolated person, with our own individual conflicts and sufferings and trials. We throw them all into the fire of Christ's Love—or, if you prefer it, into the furnace of the Holy Spirit. In those flames we are purified of everything that isolates us, everything that is merely private, merely our own, and we are melted down to become a "new creature" with a new identity, a higher "personality."

The discovery of our true selves, our own inviolable and individual beings united without confusion in this One Mystical Person, united to one another in the flame of Christ's infinite and selfless ecstasy of Love for His Father and for us will constitute one of the purest perfections of our joy in heaven.

Thomas Merton, Bread in the Wilderness

MYMENSINGH NEEDS — A LARGER OUT-PATIENT DEPARTMENT . . . Every morning the crowd of sick and poor coming to the Out-Patient Department of St. Michael's Hospital, Mymensingh, East Pakistan grows larger.

This is a disease-ridden area where the

PERPETUAL GRINDING POVERTY

of the people predisposes them to all kinds of diseases — malaria, typhoid, Kala Azar, amoebiasis, malnutrition, peptic ulcers, and T.B.—men, women and children. They come from 20 or 30 miles away, pitiful cases that can't be turned away.

We need a larger Out-Patient Department for Mymensingh. Won't you help us to double the facilities there? Your reward for this will be double too, because it will be stored up in Heaven where it will draw interest for all eternity. (Cost: $15,000.)

MEDICAL MISSION SISTERS, Philadelphia 11, Pa.

Dear Sisters: Please credit my account for $..... payable to Mymensingh Out-Patient Department.

Name.....

Address.....

City..... Zone..... State.....